Attachment #4

RIte Care / Commercial Rate Oversight Options

	Private Negotiations	Private negotns with disclosure	Private off Medicare with disclosure	Private with veto by State	Fixed % of Medicare	All payer Rate Setting
How it would work	Status quo	Method and level of payment as is,but state collects and publishes information,compares across methods where possible.	State sets case-based payment methodology to standardize across payers. Payers negotiate base rate with hospitals. Common methods makes comparisons easier.	Status quo but state has veto power over rate trends as part of insurer premium rate filings. (Could set methodology too.)	State sets methodology and % of Medicare to be paid. Revisit annually. Link to Medicaid.	State establishes a rate setting commission, like in Maryland – with or without Medicare's participation.
Fairness among hospitals and payers ("equal pay for equal work")	Rewards negotiating leverage, not necessarily value.	Public accountability would eventually promote this, but comparisons of payment levels made difficult without common methods.	Public accountability with greater ability to compare across hospitals. Could have trigger to prevent excess trend increase.	State would not have power to alter contract terms with individual hospitals.	Consistent with Medicare – for better and worse. Like Medicare, greater transparency in payment levels.	Rate-setting process and outcomes would be public – but also potentially subject to competence and political influence.
Potn'l to address areas of concern to CHTF (outpatient competition, system planning, fin. analysis, CON etc.)	None	Low	Low-Moderate: e.g., could reduce commercial insurers' rates cross-subsidizing inpatient and outpatient services.	Low-Moderate: e.g., takes all of an insurer's inpatient and outpatient rates into account.	Moderate: e.g., financial incentives to hospitals more predictable and consistent.	High: e.g., requires large amount of system planning.
Ability to control system costs (align incentives across delivery system)	Little	Public education may put more pressure on hospitals or health plans to align incentives, but not directly - could be more inflationary.	Public education may put more pressure on hospitals or health plans to align incentives, but no direct incentives	Review of overall rates could force more alignment between hospitals and health plans for global contracting.	Not much - dependent on changes in Medicare, if any.	No evidence this has happened in MD. But would have more measurement with database.
Enhance/ promote clinical quality			Same pay for performance as Medicare.	Health plans could require more from hospitals in order to reduce rate increases.	Same pay for performance as Medicare.	Could do some pay for performance.
Effect on population health	Specialty (not preventive) services receive higher pay	Specialty (not preventive) services receive higher pay	Specialty (not preventive) services receive higher pay	Hospitals/health plans accountable for rate trends tied to current mix of services.	Specialty (not preventive) services receive higher pay	Could rebalance payments according to services with greater effect on population health.
State resources		Some analytical resources.	Some analytical resources – share with Medicaid	Expands premium review process.	State conducts financial analysis on fair %.	Larger: $2-3 million/year